
THE HABIT
ALCOHOL & DRUG ABUSE DIVISION
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TOLL FREE NUMBER 1-800-45-RADAR

This number provides a prevention clearinghouse for Montana. It will provide information and pamphlets and answer questions on prevention or treatment. An answering machine answers at night.

June, 1992

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ARTICLES IN THIS ISSUE:

LIGHTHOUSE ALCOHOL SERVICE CENTER MERGER ANNOUNCEMENT

The Department of Corrections and Human Services, Alcohol and Drug Abuse Division (ADAD), announced today a series of steps to enhance chemical dependency treatment services provided by the Lighthouse Drug Program and the Alcohol Service Center (ASC) located on the Galen Campus. Effective July 1, 1992, the 15-bed 90-day Lighthouse Drug Program will be restructured to a 15-bed 60-day Extended Care Program serving both primary drug and alcohol dependent patients. This Extended Care Program will be relocated in a wing of the ASC Building.

"The reorganized program will maintain the current staffing level without a reduction in FTE's. Our extended care concept will increase the daily utilization and completion rates of the program," said Roland Mena, Supervisor of the Galen alcohol and drug program.

The Alcohol Service Center (ASC) will continue to maintain its 72-bed, 28-day program and 12 bed orientation program. In addition, the ASC Program will benefit by having enhanced staffing during the 11:00 p.m. to 7:00 a.m. shift.

Housing the Extended Care Program with ASC will allow the patients in Extended Care to use the services currently in place at ASC. Among these services are included, handicap access, lectures, audio/visual tools, self help groups (including Alcoholics Anonymous and Narcotics Anonymous), recreation and the availability of on-site medical staff.

Details of the reorganization plan for chemical dependency services at Galen have been outlined for public comment in two sources; the FY 92 - FY 95 State Plan for Chemical Dependency Services and the Alcohol and Drug Abuse Division newsletter; The Habit. The extended care and 28-day program are two key components of the reorganization. The other key elements to be implemented at a later date include a fourteen day short term program and the Detox, Education, Assessment and Referral (DEAR) program. This plan, when completely implemented, will ensure that appropriate chemical dependency services are available to all Montanans. This plan has been reviewed and endorsed by the Montana Advisory Council on Chemical Dependency, Montana's many community based chemical dependency programs, and many court judges.

NEWS FROM GALEN - ROLAND MENA

Galen Up-Date

* The ASC and Lighthouse programs will begin random urinalysis on 20% of the population by July 1, 1992. The analysis will be conducted by the Montana State Prison Lab and results communicated by the primary counselor in the patient's discharge summary. We are recommending that patients be re-tested 30 days after discharge from Galen by probation, parole, pre-release centers and other appropriate sources of referral for purposes of accountability. It is our goal to maintain a safe drug free program to provide our patients with the best opportunity for sobriety.

* Galen chemical dependency program has entered into an agreement with SRS state medical and managed care of Montana to reserve (2) two beds for individuals in need of residential treatment for chemical dependency. These recipients will be screened in a state approved program and referred back to aftercare which will be mandatory for continuation of SRS benefits. We feel this is a critical population in need of immediate care and look forward to providing these services.

* Currently we are reviewing our waiting list to establish an accurate picture of the list and begin to develop methods to better serve those individuals seeking treatment in the most timely manner. We are strongly encouraging our referral sources to please provide us with a courtesy call when you become aware of a cancellation or you need to re-schedule.

* In keeping with our state plan we are encouraging all individuals seeking treatment and referents to go through their local state approved chemical dependency program for an initial screening and referral to Galen. This will present an opportunity for the individual to become familiar with the program they may be returning to for aftercare and also possibilities to encourage and involve family members and significant others.

If you have questions about the above report or other issues concerning Galen Chemical Dependency Programs, please feel free to contact Roland Mena (693-7363). Your support is greatly appreciated.

DEPARTMENT FOUR YEAR PLAN

A hearing was held at the Department of Corrections and Human Services on May 14th to receive public and written comment on the Comprehensive Chemical Dependency State Plan. The majority of comments were in favor of the state plan and in particular the plan for the improvement of Galen services. Issues raised at the hearing included better clarification of priority populations for admission to Galen, the waiting list at Galen, and request to include treatment of family members if more funding becomes available in ADAD's goals and objectives. This was the culminating activity for formulation of the four year state plan which began with the county commissioners completing their county plans for fiscal years 1992-1995.

ADAD would like to thank the county commissioners, state approved programs, and all those that provided information and public comment for the successful completion of the state plan.

THE TURNING POINT, MISSOULA

Program Manager, Peg Shea.

This new outpatient program, part of the Western Montana Mental Health Center, contracts with the state of Montana and Missoula County to provide chemical dependency services to Missoula area. Targeted client population consists of: repeat DUI offenders, referrals from the criminal justice system, Project Work Program and Department of Family Services (DFS), pregnant women, women with dependent children, and aftercare services for Galen graduates and intravenous drug abusers. Turning Point's Advisory Committee includes representatives from the Department of Social and Rehabilitation Services (SRS), Family Services, the schools, the criminal justice system, private providers,and one consumer. Consumers are those who use the chemical dependency treatment system. Ms. Shea feels "consumers add a human perspective in planning." The clinic serves approximately 100 clients who are primary alcohol/drug abusers.

Aims to be different

Turning Point aims to be different from some other outpatient programs in three areas: serving more of the "critical population", improved access, and early treatment. Turning Point focuses on primary services, for those actively abusing substances, rather than dealing with family of origin therapies. Focusing on targeting critical populations is a new emphasis in Missoula drug and alcohol treatment. Many referrals to Turning Point are legal referrals, General Assistance (G.A) clients, and clients from SRS and Family Services, including women with dependent children. Turning Point has a close working relationship with the GA office; some clients are required to attend treatment to receive benefits or have benefits extended. Over half of clients are legal referrals; roughly ten percent of clients are "homeless." The critical population has more mental health needs and medical complications than other clients, Ms. Shea said. Turning Point has access to these services as part of the Western Montana Mental Health Center. Court ordered evaluations are also done at Turning Point.

Peg said that the facility "tries not to mix patients", i.e., mixing critical populations with less needy groups. This procedure was more common until Montana's last Legislative Session decreed that the public dollar must now be targeted to the most needy. She explained that for agencies to grow, they must receive new revenue. They do this mainly by attracting private payees (those whose insurance covers treatment, including people with less severe need for treatment). "Turning Point is not trying to grow or expand, just to meet the need," she said.

Outreach program is novel

According to Ms. Shea, "the most novel part of Turning Point's services is the outreach program." The two outreach staff work one week on/one week off so that someone is available 24 hours a day. They handle all alcohol and other drug emergencies, plus do public education and information. Every six weeks they do a two hour lecture. For instance, ongoing, structured lectures are offered for groups which deal with critical populations, including Women Infants Children (WIC) clients, Women's Opportunity Resource Development, Inc. (WORD) or other groups requesting drug education lectures. Emergency intakes are handled by Outreach also. Outreach is part of a "primary network" assisting people coming out of Galen's residential treatment.

Outreach assists these recovering people to find housing or other necessary adjustments. In addition, Outreach provides transport for those needing to return to Galen.

A new twist, Peg said, is developing a First Friends Volunteer Program to connect with special needs groups (i.e., developmentally disabled, adolescents or those out of the mainstream who have problems connecting with self-help groups. A Check-in Group is held three times a week for chronic alcoholic/chemically dependent people on the waiting list to get treatment.

Besides outreach, the other main components are clinical services - split into a men's track, a women's track, and an intensive adolescent outpatient track to begin July 1, 1992; and the ACT program (which "pays 25% of the rent", is freestanding and revenue neutral). Men and women are segregated in treatment because "men and women have different issues and also sometimes act differently in mixed groups than in same sex groups. (For example, women may try to "take care of" the men rather than focusing on their own work.) This may be the only group of this type in Montana; however, Peg has seen same sex treatment grouping in other states.

Intake orientation every two weeks starts with about 25 people. Clients are first assessed individually, then clinical staff meet to discuss assessments. The youth component will include weekly family therapy work, weekend activities like recreation, and two family nights per week from 6 to 8 p.m. The men's and women's components each consist of two phases of continuing care: Primary Care for a total of 60 hours over six weeks, and Phase 2 for four hours a week for twelve weeks. The only coeducational class is a six hour initial Education Class; after that, men and women are in different phases until Aftercare two hours a week for twelve weeks. All services are offered in the evening.

CDPM CORNER - MIKE RUPPERT

The field is currently undergoing major changes. The following article taken from HEALTH WIRE, CHEMICAL DEPENDENCY TOPICS, JUNE, 1992 is presented as representing the new forces influencing our business.

OUTPATIENT OPTIONS SAVE LIVES...AND MONEY

Jerry was an ideal candidate for intensive outpatient treatment. His job was so high pressure that even a hint of a drinking problem might mean instant dismissal, and he could not take four consecutive weeks away from his desk-for whatever reason. Soon after the vice president called him in to discuss a decline in performance, Jerry took his wife's advice and contacted the employee assistance program to inquire about treatment options.

In an era when every health care expenditure is under scrutiny, intensive outpatient treatment offers a cost-effective alternative to traditional inpatient programs. More important, a well designed outpatient treatment plan effectively meets the needs of a select group of patients-those who need help but are still able to function at least moderately well in their own work and home environment.

Jerry's drinking problem was serious enough that he could not expect to get any long-term help from Alcoholics Anonymous or even an outpatient mutual help group. On the other hand, he had as yet suffered no serious medical complications, had a stable marriage and was highly motivated to remain at his present level of employment. Even though he initially denied being dependent on alcohol, he willingly relinquished evening and weekend hours to participate in a structured therapy program.

While allowing him to live at home and maintain his regular work schedule, Jerry's treatment plan included many of the components essential to inpatient treatment. He attended lectures about the disease process, learned about relapse prevention and went to regularly scheduled individual, group and family therapy sessions. His aftercare plan included family and group therapy as well as AA.

A physician was available to conduct the initial physical examination, to help manage withdrawal symptoms and to answer questions about the disease.

The High Cost of Alcoholism

Intensive outpatient programs are by no means new, but in recent years they have attracted attention as a way to control health care costs.

As the country's most expensive health problem, alcoholism accounts for at least 15 percent of our national expenditures for health care. Direct treatment costs alone total about $13.5 billion a year.

Alcoholism has always been costly, not only in wasted lives but in lost productivity and in treatment from complications officially attributed to liver disease, heart disease, cancer or broken bones. One recent study of 300 patients hospitalized for orthopedic, surgical or internal medical problems found that 60 percent of the males and 24 percent of the females were either active alcoholics or alcohol abusers. In most cases, this diagnosis never made it into the medical records.

Only since 1957 has the American Medical Association recognized alcoholism as a disease; only since the early 1970s have insurance companies been willing to pay for treatment. According to one survey, 68.5 percent of private sector employees are now covered for alcoholism treatment compared to only 36.2 percent in 1981.

As costs rise, insurers, employers and care managers are prepared to examine alternatives to inpatient treatment. Health care professionals, on the other hand, point out that such alternatives make sense only if they are successful in reducing or eliminating the indirect as well as the direct costs of drug dependence.

Inpatient versus Outpatient

While health care professionals feel they know from experience that certain types of treatment work better for certain types of patients, they have until recently lacked controlled studies to support their views.

An article published in the July, 1986 American Psychologist has been often cited by those claiming that the type of treatment does not matter. This article reviewed 26 studies comparing inpatient versus outpatient treatment and concluded that the studies "consistently showed no overall advantage for residential over non-residential settings, for longer over shorter inpatient programs, or for more intensive (expensive) over less intensive interventions."

A more recent study, however, published September 12, 1991 in the New England Journal of Medicine, reached opposite conclusions.

Of 227 employees identified as having alcohol problems, approximately equal numbers were randomly assigned to: 1) inpatient treatment followed by AA, 2) AA without hospitalization, or 3) a treatment of their choice. After two years, the results were unequivocal: those given inpatient treatment had the greatest decline in abusive drinking; and "the differences were especially pronounced for workers who had used cocaine within six months before study entry."

Because they were more likely to relapse, those in the AA group spent three times as many days in the hospital as those in the inpatient group. In fact, inpatient treatment costs for those in groups 2 and 3 averaged only 10 percent less than for those assigned to hospital treatment.

What the study confirmed, most professional feel, is the eventual cost-effectiveness of good, comprehensive treatment-whether it is inpatient or outpatient.

Most studies show that alcoholics need less medical care after treatment than before. A 1986 study conducted for the NIAAA concluded that "total health care costs declined significantly following treatment of alcoholism." Even though the cost of inpatient treatment can be substantial, this study showed that the cost was ordinarily offset within two to three years by a decline in other health care costs.

Matching Treatment with Patient Needs

The subjects in the recent New England Journal study were all employed and covered by a company-sponsored employee assistance program. When identified as having a drinking problem, all consented to treatment.

From 11 to 17 percent in each group, however, were eventually fired for drinking problems, and for these individuals the treatment assignment was not statistically significant.

Motivation, employment status and family environment undoubtedly play important roles, and any good treatment plan takes these factors into account. In Jerry's case, as in many others, intensive outpatient treatment may be not only the most cost-efficient but the most effective treatment.

Authors of the New England Journal study called for an examination of "alternatives to the hospital other than AA," including structured outpatient programs.

As the medical director of one treatment program put it, "You really have to individualize. If you focus on all the needs of each patient, then I think you're going to have the best chance of reducing costs and all the other consequences of dependency."

Evaluation Corner
Norma Jean Boles

The Alcohol and Drug Abuse Division has issued two contracts to study Problem and Pathological Gambling.

The first contract awarded was to Replicate the South Oaks Gambling Screen to Determine the Incidence and Prevalence of Pathological Gambling in the State of Montana.The recipient of this contract was Dr. Joe Floyd at Eastern Montana College , who is contracting with Dr. Rachel Volberg for data analysis. Dr. Volberg has conducted Incidence and Prevalence studies in nine states and New Zealand.

The second contract was awarded to Susan Wallwork, University of Montana, who is subcontracting with Dr. Rachel Volberg and Jean Falzon, Executive Director of the National Council on problem gambling.This contract provides research into issues related to treatment of Pathological gamblers in Montana and was mandated by H.B.909. The study is divided into three areas as follows:

- Survey of all treatment professionals and treatment facilities in Montana;
- Literature review of treatment which is international in scope with corresponding critique;
- Recommendations for credentialing.

The Alcohol and Drug Abuse Division feels fortunate to have the caliber of expertise demonstrated by the recipients.

Both studies will be completed by October 30, 1992 and reported to the January, 1993 Legislative Session.

ALCOHOL & DRUG INFORMATION SYSTEM (ADIS)

UPDATE - THE FUTURE IS HERE!

In 1976 the Alcohol & Drug Abuse Division implemented the first reporting system for individuals receiving services from state approved chemical dependency programs in Montana. Designed to protect the identity of the client by using a confidential client identification number, the system collects social and demographic information and alcohol and drug use history for statistical purposes. This reporting system, critical to both planning and service delivery, provides the "backbone" of chemical dependency services around the state.

In 1990 the U.S Congress implemented the Anti-Drug Abuse Act of 1988, which required all states receiving federal funds for chemical dependency services, participate in a uniform data collection system. After two years work utilizing division staff, the department's Information Systems Bureau and an independent contractor, the state system was redesigned to include the data items required by congress. Funds to redesign and implement the new reporting system were awarded all states through a three year grant. The Alcohol & Drug Abuse Division completed work on the new system in June of 1991 and the reports were implemented July 1, 1991. At that time the department began monthly transmission, by modem, of all collected data to NIDA and NIAAA in Washington D.C.

A major goal identified by the division a number of years ago was to eventually design a system that would allow the treatment programs to electronically transmit this data using their personal computers. Since 1976 all data for the ADIS has been mailed each month to our office; this involves thousands of forms each year being handled by a number of individuals. In June our goal for the future became a reality.

JOHN BRODERSEN, Information Systems Bureau Chief, and **MARY LETANG,** Software Specialist, began work early in January to develop programs and obtain equipment that would allow state approved treatment facilities to electronically transmit the ADIS data to our office.

The state institutions administered by the Department of Corrections and Human Services now have direct lines that permit inputting data into the department's mainframe computer. **JOHN BRODERSEN** traveled to Galen in May and installed the hardware and software necessary for Galen to attach to the department's mainframe. Montana State Prison and the Galen Alcohol Service Center now have the capability of entering all client admission, discharge and follow-up reports into the mainframe computer in Helena. This will eliminate hundreds of forms being mailed each month and save a great deal of staff time.

MARY LETANG designed and wrote a Users Manual which provides specific instructions to program staff to input their data into our mainframe computer. In June, **MARY**, along with **NANCY McGRORTY** and **PHYLLIS MacMILLAN** from ADAD, traveled to Galen to train their personnel and assist them in beginning this new project. This month's reports from Galen have now been input and will be reflected by a savings in the staff time required to submit hundreds of reports to the Helena office each month.

Plans are now underway to begin working with individual treatment programs to begin electronically transmitting their ADIS records by modem each month. By the end of this fiscal year (June 30, 1993) it is hoped that all programs will be able to transmit data to the central office by phone. This project will eliminate a tremendous amount of paperwork.

The Alcohol & Drug Abuse Division is grateful for the work done by **JOHN BRODERSEN** and the ISB staff to make this long hoped for goal a reality. We offer our appreciation to **MARY LETANG** for her time and work to travel with us to Galen and provide, not only an instruction manual, but individual training to the Galen staff to help make our reporting goals a reality.

CONTINUING EDUCATION REQUIREMENTS

Due to the changes in the certification eligibility requirements in March of 1991, criteria identifying course content for approved continuing education credit has been included in the requirements for counselor recertification. Because minimum education requirements are necessary before an individual applies for certification, the purpose of workshop approval affects only fully certified chemical dependency counselors. The requirements for continuing education course approval for Montana Certified Chemical Dependency Counselors are as follows:

Approved Course Criteria

The content of all continuing education courses must be relevant to alcohol/drug counseling; must be related to the scientific knowledge or technical skills required for alcohol/drug counseling; or, be related to direct and/or indirect client care. Approved courses are not limited to specific alcohol/drug topics, but may include training in other human service areas, such as child abuse, grief, dually diagnosed clients, stress management and sexuality.

Courses in administration, management education, research or other functional areas of alcohol/drug counseling related to indirect patient/client contact will be acceptable.

Courses leading to basic counselor training are not acceptable as continuing education courses. Courses which deal with self-improvement, changes in attitude, financial gain, and those designed for lay people are not acceptable. Examples of unacceptable course offerings would include the following:

* Courses which focus on self-improvement, growth, changes in attitudes, self-therapy, and self awareness;

* Parenting or other programs that are designed for lay people;

* Liberal arts courses in music, art and others unrelated to the alcohol/drug counseling profession;

* Orientation programs, meaning a specific series of activities designed to familiarize employees with the policies and procedures of an institution or agency.

Continuing education credit is not granted for partial attendance of an approved workshop; i.e., attending one day of a two or three day workshop.

During the last year the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) has published similar criteria for acceptable continuing education courses for national certification. Montana counselors interested in maintaining their NAADAC certification will also be required to meet the criteria identified above.

New Certifications

Congratulations to the newly certified Chemical Dependency Counselors. The following have been certified since the last Habit publication:

Cynthia Hughes Wolfe
Diane Feland
Calvin Jefferson
Steven C. Lockrem
Michael Frank
Janice Waltner
Polly Eames
Donna Skovgaard
Lavonne E. Rice
Deborah Monteau
Robert Littlelight
Ella Dugan
Barbara A. Jenkins
Cynthia Murie
Rick Wolfname
Cheryl C. Isaacs
Jackie Cohn
Darrell Rides At The Door
Madeline H. LaValley
Dirk Gibson
Mildred M. Pierce
Carol Kummer
Myron L. Littlebird
Connie Peterson
Loyd Smith
Julie G. Chriske
Mary Greene
Gary R. Kent
Katherine A. Wilson

DARE ADVISORY COUNCIL ACTIVITIES

Attorney General, Marc Racicot, has challenged the Montana State DARE Advisory Council with developing guidelines by which DARE will operate. The council represents a variety of entities which are vitally involved in drug abuse education. Members are selected from areas of education, community, law enforcement as well as parent groups.

The Advisory Council has developed the following goals: to enhance public awareness of the DARE program; to develop a stable funding base; and to maintain and enhance the quality of the DARE Program. This group will aim for increasing community involvement, informing the public through press releases and newsletters, promoting the DARE income tax check-off and encouraging fund raising and budgetary commitment at a city-county level. Other objectives are to evaluate this statewide program, develop officer recruitment standards and officer conduct standards, continuing education requirements and standards for fund raising on the local level.

Members of the Advisory Council are: Ellen Bourgeau, President, Montana Parent/Teacher Association; Mark Brown, Montana DARE Officers Association; Darryl Bruno, Administrator, Alcohol and Drug Abuse Division; Joan Cassidy, President, Montana Communities in Action; Larry Conner, Assistant Chief, Bozeman Police Department; Cheryl Davis, Coordinator, Yellowstone County DARE Program; Eric Feaver, President, Montana Education Association; Joe Gauthier, Chief, Cut Bank Police Department; Nancy Keenan, Superintendent of Public Instruction; Colleen McCarthy, Helena City Commission; Jim McGarvey, President, Montana Federation of Teachers; Terry Osborn, Montana DARE Officers Association; Rick Ross, President, Montana Sheriffs and Peace Officers Association; Mignon Waterman, State Senator; Ed Hall, Administrator, Board of Crime Control; Marc Racicot, Attorney General. Staff members are Fred Fisher, Drug Prevention Education Coordinator and Jan Dye, Administrative Assistant.

For further information on the DARE Advisory Council please contact Fred Fisher at the Attorney General's Office, 444-2026.

ADAMHA REORGANIZATION

Major changes in the Federal system for the provision of alcohol and drug abuse treatment and prevention services are proposed in the conference bill for the re-authorization of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). The Senate has passed the conference bill. Action should have been taken by the House of Representatives by the time you read this article. The central feature of the re-authorization bill is that ADAMHA, the agency which has been the major source of Federal funding for both programming and research, is being re-organized. The research functions housed in NIAAA, NIDA, and NIMH are being moved to the National Institute of Health (NIH). The substance abuse treatment, alcohol an other drug abuse prevention, and mental health activities are being combined into a new agency, the Substance Abuse and Mental Health Services Administration SAMHSA. Within SAMHSA activities will be managed by three agencies:

a. Center for Substance Abuse Treatment (CSAT) - formerly OTI
b. Center for Substance Abuse Prevention (CSAP) - formerly OSAP
c. Center for Mental Health Services (CMHS) - new agency

Key provisions of the act as proposed in the May 14, 1992 conference report are as follows.

1. States are still required to expend not less than 35% of the block grant for treatment of alcohol and 35% for other drugs.

2. The 10% set aside for services to women and pregnant women has been eliminated. However, states are required to expend a 5% increase in services to pregnant women/women with dependent children for FY93 over FY92 levels and, an additional 5% increase in expenditures for FY94 over FY93 levels. This increase may be achieved through either new programs or by expanding the capacity of existing services. After FY 94, a State must not be less the FY94 level. Further, services to pregnant women and women with dependent children must include prenatal care and child care. Prenatal care and child care may be provided either directly or through provisions with other agencies.

3. The IV Drug set aside has been eliminated, except for states with a high incidence of individuals testing HIV positive or with AIDS.

4. The 20% Prevention set aside must be spent on primary prevention activities, not for early intervention services to individuals who require or are receiving treatment.

5. The FY94 Block Grant will be contingent upon a State passing and enforcing laws to prohibit the sale of tobacco and alcohol to persons under age 18.

The proposed legislation with changes in the ADMS Block Grant allocation formula includes the first major increase in funding for Montana since 1988. The re-authorization also increases the amount money available to serve critical populations through categorical grants.

THE HABIT - May 1992

GAO: INDIRECT PREVENTION WORKS BEST

(From Alcoholism and Drug Abuse Weekly, March 18, 1992)

Adolescents would rather believe (and have others believe) they are joining a recreation league or community program rather than enrolling in a drug and alcohol abuse prevention program, a new report from the General Accounting Office (GAO) concludes.

Citing participant enthusiasm as a key component of the most successful prevention programs aimed at 10- to 13- year-olds, the GAO found that programs were found to be attractive for things like free meals and sports activities, rather than for the underlying purpose: drug and alcohol prevention.

In fact, many programs approached drug and alcohol use indirectly, focusing on self-esteem and peer role models rather than the substances themselves. And some even turned down funding sources that would have required a more direct approach to chemical dependency.

Program officials said participants would be less attracted to a straightforward drug and alcohol prevention program because they would not want to be labeled as having an addiction problem.

The GAO report found that youths were more attracted to programs that were culturally sensitive, stressed youth participation and empowerment and offered structure and discipline, among other features.

The community-based programs were often the only safe, drug free environment that the target group had available, the report said. Program officials told GAO investigators that participants would be less attracted to a straightforward drug and alcohol prevention program because they would not want to be labeled as having an addiction problem.

While anecdotal evidence suggests that indirect prevention programs are more successful in attracting youth, a lack of outcome data hampers scientific evaluation of the programs, the GAO report said. The report stressed the need for more funding for outcome studies.

The report's findings are somewhat ironic, since one such major "indirect" prevention effort -- the establishment of midnight basketball leagues in drug-plagued communities -- was sharply criticized in Congress last year and had its funding eliminated to boot. The GAO surveyed 226 programs for the report and staffers visited 10 of these. Activities provided by the various programs included vocational training, performing arts, tutoring, family field trips and sports.

CONFERENCE REPORT

Director, Report Say Oxford House Is a Success

The drop out rate at Oxford Houses nationwide has remained under 10 percent despite the rapid growth of the program, Executive Director Paul Molloy said at the recent Substance Abuse Linkage Initiative Conference in Washington, D.C.

"In part this small "flunk out" rate may be because treatment providers are preaching Oxford House from early on in treatment and Oxford House itself does more training of new house residents than was true prior to the expansion which has taken place over the past three years," said Molloy.

From June 1989 to [February 1992], the network of Oxford House residences for recovering alcoholics and drug abusers grew from 22 homes to 336 homes. There are currently homes in 28 states, and the expansion has been fueled by a 1988 federal law that requires states to establish a loan fund for prospective Oxford Houses to draw upon for start up costs.

The group homes are self-run and self-supporting, with residents chipping in to pay rent and expenses. They operate under one principle: all residents must remain sober; those who relapse are expelled.

There is no limit on how long residents can stay in an Oxford House, and the low cost of living in the group residences seems to act as a buffer against homelessness for many. For instance, Molloy released a report by the National Catholic School of Social Services on Oxford Houses in Washington State and Oregon, which found that 31 percent of residents were homeless before coming to live at the group homes.

About three of four reported being homeless at some point in their lives.

Molloy stressed the need for treatment providers to link with local Oxford Houses as an aftercare option for many of their clients.

"Ideally, every treatment provider should be packaging six to 12 clients and encouraging them to rent a group recovery home and become an Oxford House," he said. "Time and education will help this evolution occur."

He said Oxford House outreach workers contact providers, business groups, recovery groups like AA and NA and church leaders, among others, to set up a support network for the homes. In fact, most residents surveyed said they had heard about Oxford House either through their treatment center or through AA or NA.

ADAD contracts with Keystone Homes, an affiliate of Providence Treatment Center, to provide Montana's equivalent to the Oxford House. Presently, Keystone Homes has two male homes in Missoula and in process of approving a female home in Great Falls. If you are interested in this program, please contact Tom Jacobson at 727-2512 or 1-800-367-2511 for further information and application requirements.

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NATIONAL FEDERATION OF PARENTS (NFP) FOR DRUG FREE YOUTH
RED RIBBON CAMPAIGN

In communities all across the United States, the Red Ribbon has become the centerpiece of many truly grand celebrations of freedom from drugs. Summer will fly by, so mark your calendars for Red Ribbon Week October 24 - November 1. This year's theme is "Drug Free and Proud."

The 1992 campaign includes a Rally in Helena October 28, 1992 with the following agenda:

2:00 p.m. Gathering at the State Capitol for opening remarks and wrapping of the Capitol with red ribbon.

2:45 p.m. Student Parade/Red Ribbon Walk (7 blocks) to Helena High Gymnasium for the Rally and program (escorted by High School bands and local law enforcement)

3:15 Student Rally

4:15 Conclusion

4:30-6:00 p.m. Teen Dance sponsored by MTI and TIP at Helena High.

Montana Communities in Action (MCA) has entered into an agreement with NFP to become self-fulfilled within the state. That means Montana, with the help and support of NFP, will take ownership of its campaign and all red ribbon orders will be placed through MCA. MCA is a state recognized non profit organization and a statewide prevention network that provides education, resources and training to Montana communities. The Executive Board is made up of volunteers from throughout Montana.

The Board is composed of President Joanie Cassidy, Butte; Vice President Bev Braig, Kalispell; Treasurer Melisa Kaiser, Helena; Secretary Donna Stringer, Libby; Red Ribbon coordinator Chris Smith, Helena; Fred Fisher, Helena, and Carol Habets, Great Falls.

Red Ribbon Week will again unite neighbors across the country: moms, dads, small children, teenagers, law officers, public officials, merchants, senior citizens, in the annual celebration of drug free lifestyles. As a symbol of a unified and visible commitment toward the creation of a Drug Free America, red ribbons adorn clothes, doors and mailboxes, schools and businesses. Even more importantly, the Red Ribbon Campaign acts as a catalyst to mobilize communities into action. The goals are to create awareness concerning alcohol and other drug (A/OD) problems facing every community, build community coalitions to implement A/OD prevention strategies, support healthy drug free lifestyles, and encourage neighborhood prevention planning and activities.

Red Ribbon Week means many different things in many different communities. But one thing remains the same: even the small gesture of wearing a red ribbon has the potential for touching a child in a profound way, and keeping him drug free.

RISK FACTORS: AN OVERVIEW
(from Directions 1991, Kansas Alcohol and Drug Abuse Services)

Prevention Premise:
To prevent behavior before it happens, programs must address factors which put people at risk for the behavior.

Community Risk Factors:

* Economic and social deprivation.
* Low neighborhood attachment and community disorganization.
* Transitions and mobility.
* Community laws and norms favorable toward drug use.
* Availability of drugs.

Family Risk Factors:

* Family history of alcoholism
* Family management problems.
* Parental drug use and positive attitudes toward use.

School Risk Factors:

* Early antisocial behavior
* Academic failure.
* Low commitment to school.

Individual Peer Risk Factors:

* Alienation or rebelliousness.
* Antisocial behavior in early adolescence.
* Friends who use drugs.
* Favorable attitudes toward drug use.
* Early first use of drugs.

DEVELOPING YOUTH POTENTIAL: A PRO-ACTIVE APPROACH FOR THE 90'S

Second in a series by Kirk A. Astroth, Extension Specialist, 4-H Youth Development. (See the March 1992 HABIT.)

In the previous article, I discussed the risk/resiliency approach to prevention. Successful, effective prevention programs attempt to target these dual factors at multiple levels of the child's environment. Such an ecological approach considers the inter-relationship between individuals and the environment in which they live.

Since families are the most important influence on children, this article will describe the risk and resiliency factors at this level of the social ecology. If we are serious about reducing youth involvement in self-destructive behaviors, an ecological approach suggests that prevention programs need to assess which risk factors youth face, which resiliency factors are in place, and which resiliency factors are absent but might be nurtured. Resiliency factors are sometimes thought of as the opposite of risk factors, but they are more powerful than this. If nurtured, resiliency factors can foster positive youth development and help all youth--even those in adverse situations--reach their potential.

Let me caution you against viewing any of these risk or resiliency factors as single "magic bullets" or causes for youth problems. Piecemeal or band-aid approaches that result from efforts focused on a single factor to the exclusion of others will not be effective. Remember: human development is influenced by a whole mosaic of factors interacting together. Human behavior cannot be conveniently explained by one or two factors.

For example, a study by Rutter (1979) suggested that the presence of one risk factor (for example, low socio-economic status) was not much more likely to create dysfunction than when no risk factors were present. With the presence of two risk factors, however, there is four times the chance of problem behaviors. With four or more risk factors present, the risk increased to as much as 10 to 20 times. Some researchers call this an "amplifying effect." Children in these situations are at "high risk" for negative outcomes unless several resiliency factors are also present in the environment. Pittman (1991) found that the timely development and reinforcement of academic, social, vocational, and citizenship competencies had a strong preventive affect on the development of risk-taking behavior.

Now, let's examine what researchers have found to be the risk and resiliency factors at work at the family level of a child's social ecology.

IN THE FAMILY ENVIRONMENT

Risk Factors

* Poor Parental Monitoring or Supervision (See accompanying figure)
* Distant, Uninvolved or Inconsistent Parenting Styles
* Poorly Defined Family Rules, Expectations and Recognition
* Continual Marital Discord or Conflict (See figure)
* Low Parental Educational Aspirations for Children ("You'll never make it.")
* Lack of Maternal Involvement in Children's Activities
* Absence of a Father Figure at Home
* Lack of, or Inconsistent Parental Discipline Techniques
* Inconsistent and Ineffective Family Management Techniques (See figure)

Resiliency Factors

* Egalitarian Parenting Styles
* Close Personal Relationships with Adults
* Attachment to Parents or Surrogate Parents
* Close Bond with at Least One Caregiver
* High, yet Realistic, Educational Aspirations for Children
* Presence of a Nurturing Father Figure at Home

Obviously, it would take some time to explain each of these factors in detail, but let me just take one that has surfaced as important: father figures. Recent research indicates that the presence or absence of a nurturing father figure in the home is critical to the process of youth development.

For example, the research clearly indicates that boys without fathers at home have a more difficult time managing their aggression than boys who do. Often these boys have shorter attention spans. They are distracted. They have more difficulty than other boys with school performance and achievement, and they do not adjust well socially. And girls are equally affected. All the research indicates that children in father-absent homes have great difficulty with sex role and gender identification (i.e., the establishment of a satisfying identity as a male if you are male or an identity as a female if you are female). Watching their mothers struggling to raise a family alone, girls learn to expect little from men, financially or emotionally. Boys learn that their maleness is, at the very best, an ambiguous quality.

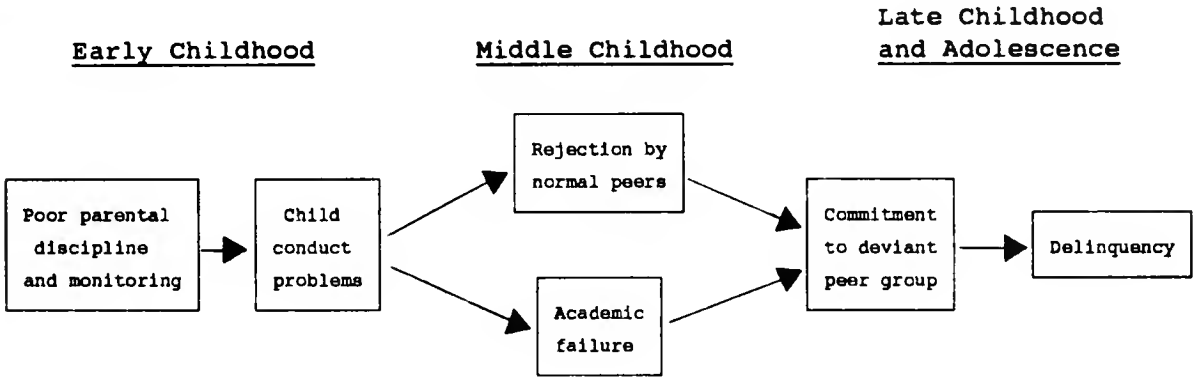
On the resiliency side, though, the presence of a father figure gives boys the feeling of being protected and "contained," which all children need. Children who spend a great deal of time with their fathers are more likely than other children to grow up to be highly empathetic adults. And watching their non-violent fathers master anger and aggression, boys learn how to cope with their feelings. Presence of a father figure in the home can mitigate boys' aggressive drive and fantasy. The predominance of aggressive motives is particularly evident in children who did not have a father figure at home between the ages of 18 and 60 months. Between 60 and 84 months of age little girls begin to exhibit similar motives if a father figure is absent. Other studies support this finding that the absence of a father figure during the pre-school years may be more detrimental than during later years.

When I have presented this list of risk and resiliency factors with other groups, invariably someone asks about the risk factor: Lack of Maternal Involvement in "Children's Activities" and ask why just maternal. Emmy Werner, author of Vulnerable, but Invincible: A Longitudinal Study of Resilient Children and Youth (1982) found that fathers typically do not participate to a great extent in children's activities while mothers usually are quite involved. Thus, when mothers are not involved, the detrimental effects impact children to a much greater extent. Other research has substantiated this difference between the roles of mother and father. In fact, research tells us that fathers who take an active role in their children's lives have a very beneficial effect. For example, children whose fathers joined their mothers in discussing the child's progress with their teachers scored up to 7 months higher in reading and math than children whose fathers were not involved. It may be that lack of a father is not as bad as having an attentive father is good.

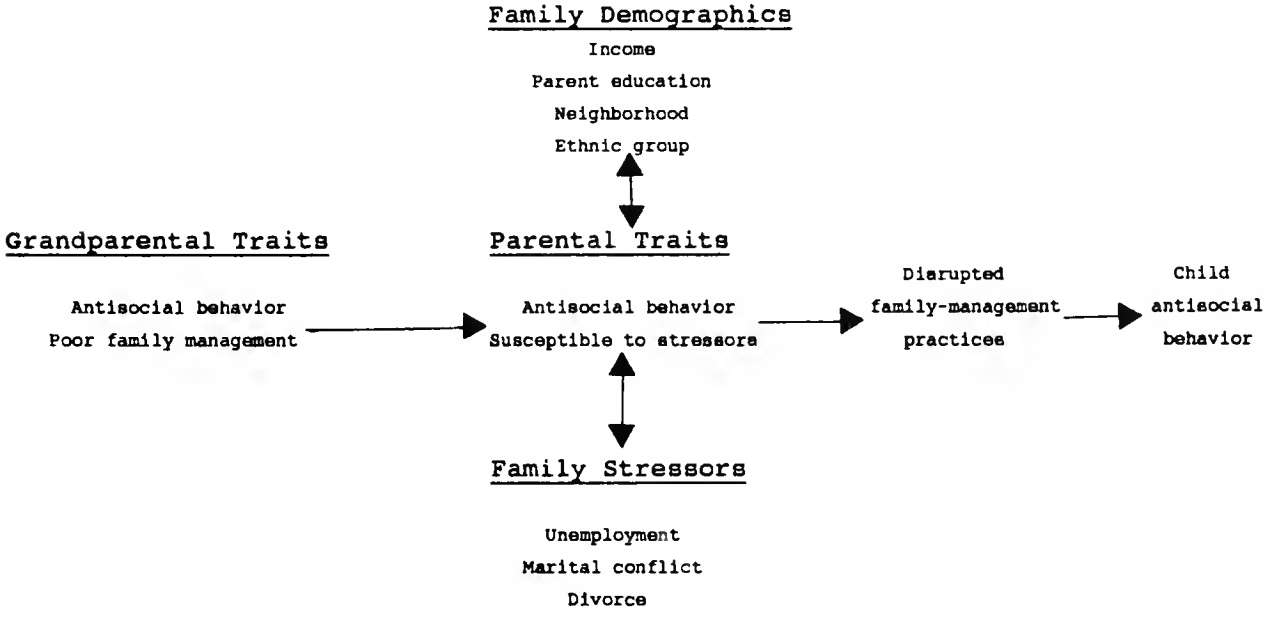
This selection has highlighted some of the risk and resiliency factors at work in the family arena. In the next article, I'll talk about some of the factors at work at the school level of the a child's social ecology.

From: G.R. Patterson, Barbara D. DeBaryshe, and Elizabeth Ramsey. "A Developmental Perspective on Antisocial Behavior." American Psychologist 44 (February 1989), pp. 329-335.

A Developmental Progression for Antisocial Behavior



Disruptors of Effective Parenting



YOUTH PREVENTION BOOK REVIEWS

All Grown Up and No Place to Go: Teenagers in Crisis, David Elkind, Addison Wesley Publishing, 1984.

As every parent knows, raising teenagers isn't easy. But raising teenagers today is tougher than ever. In this book from author of the 1981 bestseller The Hurried Child (1981), psychologist David Elkind helps parents cope with the pressures facing today's adolescents and offers insightful advice that will help parents guide their teenagers through these turbulent years. Elkind is a Professor of Child Study at Tufts University who submits that today's teens are expected to confront adult challenges at an early age, without any preparation. The normal adolescent rituals have disappeared, their symbols and trappings usurped by younger children, leaving teens "all grown up with no place to go." The results speak for themselves: drastic increases in drug and alcohol abuse, psychological withdrawal, crime, and even suicide among teenagers.

Using case studies, research, and examples gathered from the author's own practice and travels, ALL GROWN UP maintains that today's teens suffer drastic repercussions because of today's social pressures. "Teens are pressured into taking on adult responsibilities by parents more committed to their own self-fulfillment than to their children's. These parents of the "me generation" are often too quick to accept their teenagers' outward sophistication as a sign of emotional maturity. Teens' emotional needs are also neglected by a school system that is up to date in computer gadgetry and outdated in respect to individual attention. And the media, while often catering to teens in advertising, further exploit them by appealing to their vulnerability to peer pressure."

This very readable and non-technical work follows the original work of psychoanalyst Erik Erikson, exploring the primary task of the teenager as constructing a sense of personal identity. One chapter explores family permutations and the increasing prevalence of single parent families. Teens' reactions to stress comprises another chapter.

One chapter discusses vanishing "markers" or age-specific rituals which used to separate phases of childhood. Markers are external signs, public recognition of "having arrived", such as graduations, bar or bas mitzvahs. But other markers such as sophisticated clothing and competitive team sports have been usurped by younger and younger age levels, causing older kids to lose interest, the author asserts. Society no longer seems to regard children as innocent or to see childhood innocence as a positive characteristic, Elkind says. This thought-provoking book for the parent and lay person is sure to provide for a deeper understanding of today's teenager.

The Encyclopedia of Psychoactive Drugs, Alcohol: Teenage Drinking, Solomon H. Snyder, M.D. (editor) (New York: Chelsea House, 1985).

This encyclopedia, specifically written for young people, has two series of 25 volumes each. Each volume is devoted to a specific substance or pattern of abuse. Besides this volume, two others deal with alcohol: Alcohol and Alcoholism, and Alcohol: Customs and Rituals. An index and glossary accompany each volume.

Chapter 8 of this volume is on Alcohol and Public Policy.

The authors believe that the disease concept of alcoholism fits nicely with this society's ambivalence regarding alcohol, contributing to our inability to deal with drinking problems in an effective way. This book criticizes the disease concept as a simplistic one which the public likes or has accepted; in contrast, social and emotional motives for problem drinking are examined. This work on teenage drinking asserts that "prevention cannot help but step on the toes of some special interest groups." It criticizes the treatment of alcoholics as the focus of public policy on alcohol, when "few people with drinking problems ever seek help." Education efforts are criticized because "few from among the large number of people with minor but socially costly drinking problems consider treatment."

The authors argue for an emphasis on other methods of prevention, such as distribution, as opposed to education/enforcement methods. They offer as argument the drop in the historical consumption of alcohol in the United States from 1919 to 1933 during Prohibition, along with lowered rates of alcoholism (as measured by rates of cirrhosis, corrected for the time lag). Restriction of distribution in Europe, where wines were rationed during World War II, also resulted in a lower rate of alcoholism/cirrhosis. A similar phenomenon occurred in Finland when long strikes by liquor store clerks correlated with a drop in public drunkenness and alcohol-related hospital and clinic visits, the authors state. Violations of liquor laws in this country led to Repeal of Prohibition, but now there is a prejudice against any form of general control such as higher liquor taxes, they assert. States have taken action such as Massachusetts' outlawing of "Happy Hours", but this is an exception to the general trend.

ABSTRACTS
Research on Rural Population Usage

Research studies focusing on drug and alcohol use of rural youth have been rare. Recent studies on youth in Illinois, Ohio, and Michigan may have some relevance for Montana. Prominent in the study of rural alcohol/drug use is Dr. Paul D. Sarvela, an assistant professor in the Department of Health Education at Southern Illinois University at Carbondale, Illinois.

"DRINKING, DRUG USE, AND DRIVING AMONG RURAL MIDWESTERN YOUTH," Paul D. Sarvela, Deborah Jenkins Pape, Justin Odulana, Srijana M. Bajracharya (Journal of School Health vol. 60 No. 5, May 1990, pp. 215-19)

ABSTRACT: Data concerning self-reported driving after drinking or using other drugs were collected from 3,382 junior and senior high school students in rural central and southern Illinois. Drinking drug use, and driving increased steadily with age, with 42% of the 12th grade class indicating they had driven a car at least one time in the past six months after drinking or using other drugs. Riding with a driver who had been drinking also increased with age; 20% of the seventh grade sample had ridden in a car with a drinking driver, while 58% of the 12th grade sample reported having done so. Slightly more females had ridden in a car with a driver who had been drinking than males, while males reported higher rates of driving after drinking or using other drugs than females. Correlation analyses indicated 22 variables related significantly to drinking, drug use, and driving. Frequency of alcohol use variables were the most powerful indicators of self-reported driving after drinking or using other drugs in this sample.

"A DRUG EDUCATION NEEDS ASSESSMENT IN A RURAL ELEMENTARY SCHOOL SYSTEM: RESULTS AND CURRICULUM RECOMMENDATIONS," Paul D. Sarvela et al (February 11, 1988) EDRS

ABSTRACT. This report presents the results of a needs assessment study on comprehensive drug education conducted for a small rural K-8 school. A brief review examines the literature on drug and alcohol abuse among rural youth. Parents, teachers, and students were surveyed to assess their needs, interests, and knowledge of drug and alcohol abuse. Twenty percent of children in grades kindergarten through three and 43% of older children reported having tasted beer while 13% of second graders and 19% of children in grades four through eight had tried cigarettes. All students cited parents as the first source they would go to for information about drugs, although as students increased in age they more frequently cited other sources of information. Ninety percent of parents believed drug education should occur in the schools. Parents believed educational programs would focus on facts about drugs, their harmful effects on the body, drinking and driving, and the legal ramifications of drug use. The report recommends a parent education program, since parents are cited most frequently as a source of information about drugs and alcohol. Recommended goals for school drug and alcohol education programs include identification of sources of drugs; identification of people who are reliable sources of information; description of the effects of drugs on the body; a demonstration of positive, independent, decision-making skills. The report recommends that a drug education committee select curriculum materials to meet the objectives of the comprehensive drug education program. (Thirty-five references are listed, and the appendices contain six questionnaires, a table of results, and a list of recommended curriculum materials.)

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"EARLY ADOLESCENT ALCOHOL ABUSE IN RURAL NORTHERN MICHIGAN," Paul D. Sarvela and E.J. McClendon (Paper presented at the Annual Meeting of the American Alliance for Health, Physical Education, Recreation and Dance, Las Vegas April 1987).

ABSTRACT. It is important to study youth abusive drinking patterns because adolescent abusive drinking has been linked to behavioral and sociological problems. Few studies, however, have examined early adolescent alcohol abuse or have addressed the problem of abusive drinking among rural area youth. A study was conducted to assess the extent to which alcohol-related abusive behavior occurred in a rural, middle school population. Data concerning several alcohol abuse behaviors were collected from 181 middle school students in Michigan's Upper Peninsula during May 1982. The data suggest that a number of abusive alcohol related behaviors are present in this population. Alcohol misuse appeared to increase significantly with age and to increase at rates well above national averages. Reported cases of alcohol-induced illness and intoxication increased significantly as grade level increased; no significant differences were found between male and female responses (contrary to national trends). The number of respondents expressing guilt after drinking increased significantly with age, females reported significantly greater rates of post-drinking guilt than did males. These findings suggest that there is an extremely high prevalence rate of alcohol use among young adolescents in northern Michigan. Health education alcohol use prevention programs would be developed to address these problems and should be implemented no later than the sixth grade. This paper provides some recommendations for both mental health education program development and therapeutic services.

"THE PRIMARY PREVENTION OF ALCOHOL PROBLEMS: A CRITICAL REVIEW OF THE RESEARCH LITERATURE," Joel M. Moskowitz, PH.D. (Journal of Studies of Alcohol 50: 54-88 1989)

ABSTRACT. The research evaluating the effects of programs and policies in reducing the incidence of alcohol problems is critically reviewed. Four types of preventive interventions are examined including: (1) policies affecting the physical, economic and social availability of alcohol (e.g., minimum legal drinking age, price and advertising of alcohol), (2) formal social controls on alcohol-related behavior (e.g. drinking-driving laws), (3) primary prevention programs (e.g., school-based alcohol education), and (4) environmental safety measures (e.g., automobile airbags). The research generally supports the efficacy of three alcohol-specific policies: raising the minimum legal drinking age to 21, increasing alcohol taxes and increasing the enforcement of drinking-driving laws. Also, research suggests that various environmental safety measures reduce the incidence of alcohol-related trauma. In contrast, little evidence currently exists to support the efficacy of primary (alcohol) prevention programs. However, a systems perspective of prevention suggests that prevention programs may become more efficacious after widespread adoption of prevention policies that lead to shifts in social norms regarding use of beverage alcohol.

Dr. Moskowitz' article was supported by the National Institute on Alcohol Abuse and Alcoholism. **He is an associate research psychologist at the School of Public Health, University of California at Berkeley.**

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ALCOHOL AND DRUG ABUSE DIVISION

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